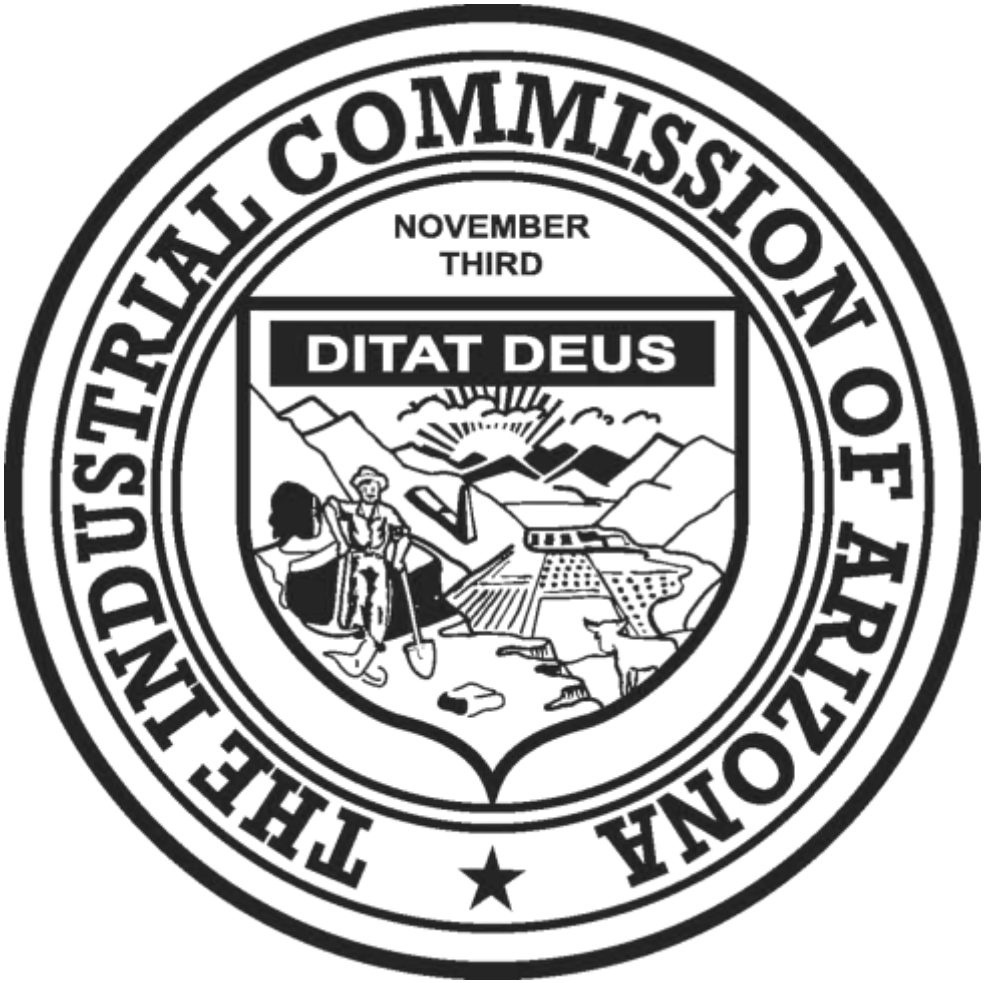
Scheduled Permanent Impairment & Fatalites

Presented By:

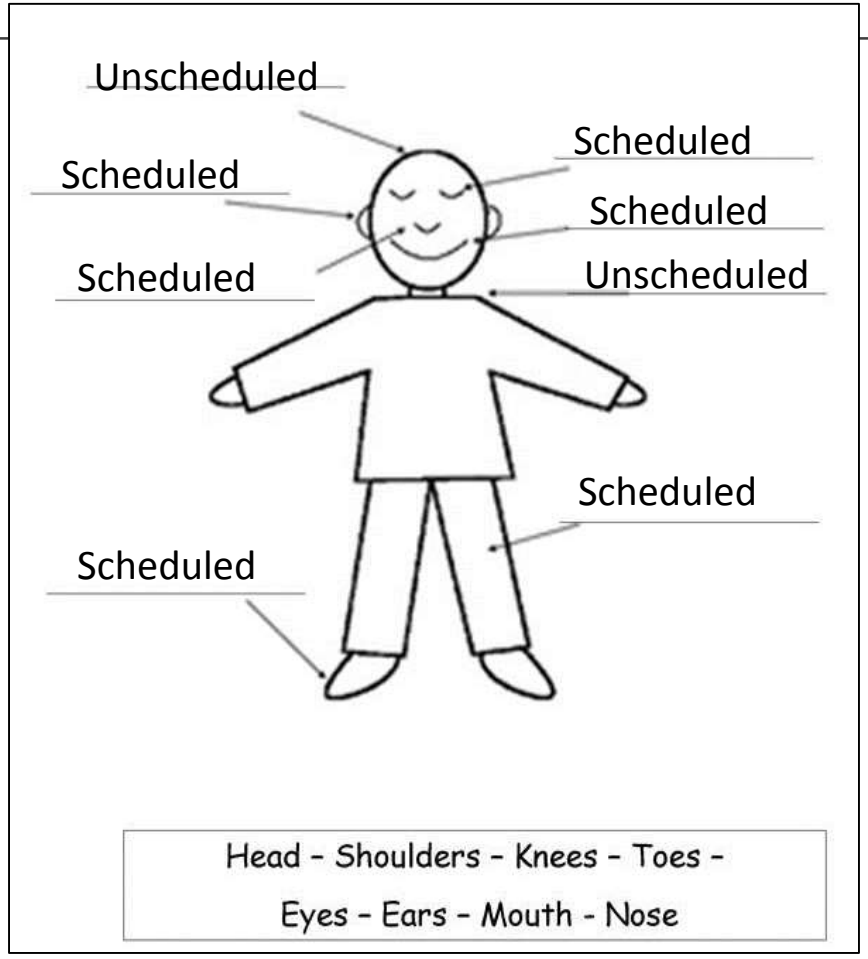
Melissa Smith, Ombudsman



Agenda

- What is a scheduled injury?
- How to Calculate the scheduled award
- How to issue a scheduled closure
- Tooth Loss & Facial Scarring
- Fatality Claims

What is a scheduled injury



PERMANENT IMPAIRMENT

SCHEDULED	UNSCHEDULED
A.R.S. §23-1044.B	A.R.S. §23-1047
Specific body part	"Whole Man"
Form 106	Form 107
Specific # of months	Possibly for life
Carrier issues award	ICA issues award

How to Calculate

To Calculate The Value Of A Scheduled Award You Must:

1. Determine the Amount of the Monthly Entitlement
2. Determine the Number of Months of Entitlement

You Will Need Two (2) Things:

1. Average Monthly Wage
2. Medical Report
   A. Body part and amount of permanent impairment
   B. Able/Unable to return to DOI occupation

Three Ways Monthly Entitlement Is Calculated
A.R.S. §23-1044(B) 21

1. 50% of AMW - Partial Loss
   Injured Worker is Able to Return to DOI occupation

2. 55% of AMW - Permanent and Complete Loss of Use, Total Loss or Amputation
   Injured Worker is Able to Return to DOI occupation

3. 75% AMW –
   Injured Worker is Unable to Return to DOI occupation

To Determine The Number Of Months Of Entitlement:

Multiply the impairment rating times the number of months for the body part

Example: body part is the foot which is worth 40 months; the impairment rating is 10%

40 months x 10% = 4 months of entitlement

Finger & Thumb Amputations
A.R.S. §23-1044(B) 6 & 7

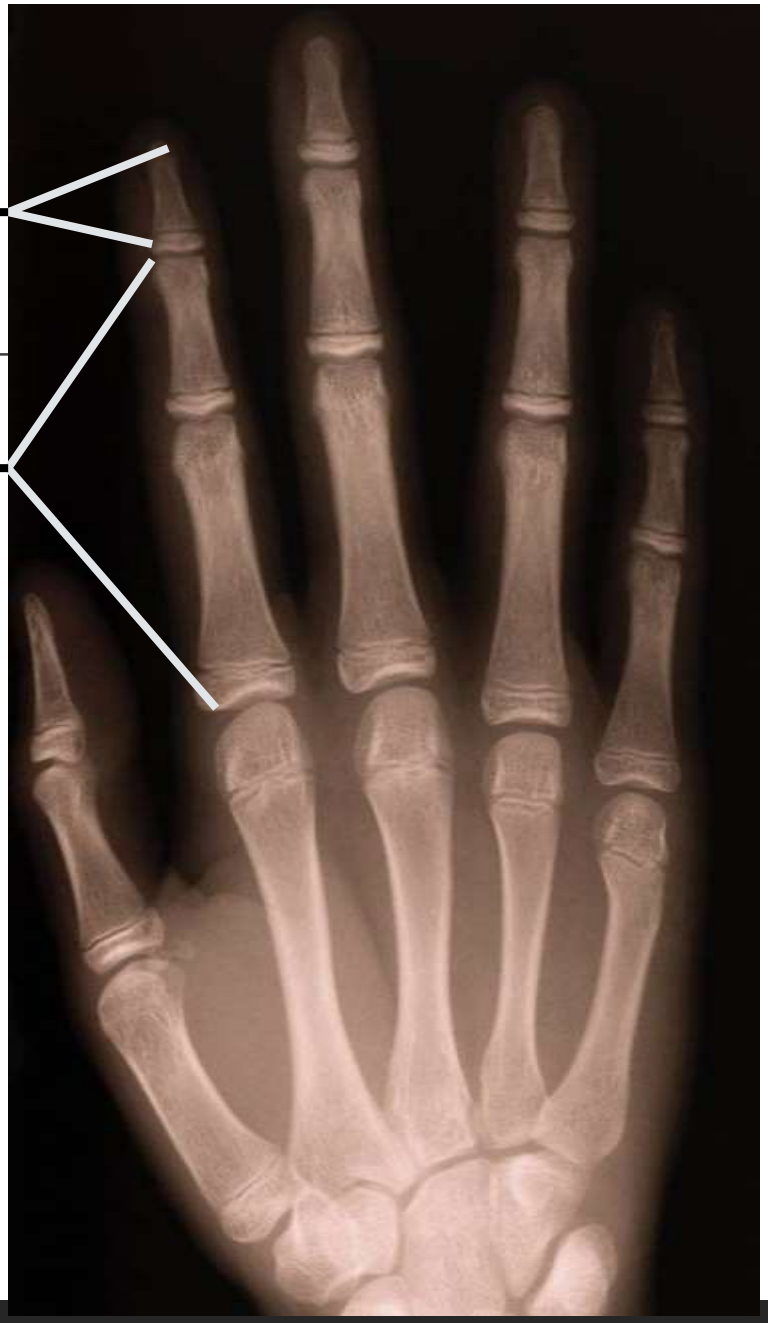
Bone loss from the tip of the finger to the first knuckle is a loss of 50%. (Substantially all)

Bone loss past the first knuckle is considered a loss of 100%.

Up to 50% Loss of Finger

100% Loss of Finger

Bone Loss in Fingers



IMPORTANT Case Law Camis

In accordance with the Camis decision of 1966, "where claimant is legally entitled to compensation under either of two scheduled disabilities, he is entitled to benefit of approach to his scheduled injury which would provide him with larger amount of compensation."

Example: Injured worker sustained the following right major hand impairment:

100% loss by amputation to the little finger: 100% of 4 months = 4 mo.*

65% impairment to the ring finger: 65% of 5 months = 3.25 mo.**

60% impairment to the middle finger: 60% of 7 months = 4.2 mo.***

Average monthly wage: $2400 ($2400 x 55% = $1320)(AMW x 50% = $1200)

* $1320 x 4 mo. = $5280
** $1200 x 3.25 mo. = 3900
*** $1200 x 4.2 mo. = 5040
$14,220 total for all three fingers

The medical report indicated that the total impairment of the fingers is equal to 29% impairment of the major hand, which is equal to 26% impairment to the major arm:

29% major hand: 50 months x 29% = 14.5 mo. @ 50% of the AMW

$1200 x 14.5 mo. = $17,400 for the 29% impairment of the right major hand

26% major arm: 60 months x 26% = 15.6 mo. @ 50% of the AMW

$1200 x 15.6 mo. = $18,720 for 26% impairment of the right major arm.

In this case, the injured worker would be awarded benefits based on the impairment to the right major arm since it is worth more than the total of each of the fingers added together and more than the major hand rating.

BEST PRACTICE ALERT! These are primarily seen in machinery accidents where the multiple fingers/hand/elbow on the same extremity. Call us with any questions when calculating!

How to issue a closure on a Claim with Permanent Scheduled Impairment

Packet For Scheduled Permanent Disability Must Be Submitted To All Interested Parties

1. Make sure wage has been established

2. Notice Of Claim Status (104) marking #6 with termination date (remember rule #18) and #8 indicating permanent disability. Also copy the treating physician with this notice.

   If wage has not been established, this notice can include #4b and attach the wage calculation sheet (108).

3. Notice Of Permanent Disability Or Death Benefits (106) with calculations for permanent disability award.

4. Medical report to support termination and permanent disability.

   (If minor extremity send supporting documentation)

5. Notice Of Supportive Medical Maintenance Benefits (103) if applicable. Also copy the treating physician with this notice.

#1 SOLICIT! Wage is to be established even if there is no time loss/compensation paid.

Scheduled Permanent Impairment

Issue 104 checking numbers 6 & 8. Submit supporting medical documentation

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address	ICA Claim No. _____ Soc. Sec. No. _____ SSN not required if correct ICA claim number is provided
Authorized Third Party Administrator (TPA) Name and Address	Carrier Claim No. _____ Employer _____
Claimant's Name and Address	Address _____ Date of Injury _____

☐ 1. Claim is accepted.

☐ 2. Claim is denied.

☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.

☐ 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:

- ☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
- ☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.

☐ 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.

☒ 6. Temporary compensation and active medical treatment terminated on **Within 30 days** because claimant was discharged.

☐ 7. Injury resulted in no permanent disability.

☒ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.

☐ 9. Petition to Reopen accepted.

☐ 10. Petition to Reopen denied.

☐ 11. Other:

Mailed on: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

NOTICE OF PERMANENT DISABILITY OR DEATH BENEFITS

Carrier or Self-Insured Name and Address

ICA Claim No. Include ICA#

Sec. No.

Authorized Third Party Administrator Nam … No.

NEW 106 has formula built in!

Claimant's Name and Address

Address

Date Injured

You are hereby notified that the above-named insurance carrier has determined that … following Permanent Disability or Death Benefits:

Reference:Statute benefits are paid under

1. Statute under which compensation is payable: § A.R.S. 23- 1044(B)(15)(21)
2. Percentage and type of disability: 10% functional loss of the leg
3. Amount of compensation and method of payment:

50 Months x 10% Impairment = 5 Months

AMW: 4,000 x 50% % = $2,000

Total Award: $2,000 monthly for 5 months=$10,000

Multiple fingers can be added here.

Other Details: The first payment effective as of (date)

Mailed On: By:

(Authorized Representative) Tel. #:

Copy to: Industrial Commission of Arizona

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

Form 106

Scheduled Permanent Impairment Award Issued By Carrier/TPA

$4,000.00 (Average Monthly Wage) x 50 % (Percentage Of AMW (50%, 55%, 75%) See Below) = $2,000.00 (Monthly Entitlement)

50 (Number Of Months For Body Part) x 10 % (Percent Of Impairment) = 5 (Number Of Months Of Entitlement)

$2,000.00 (Monthly Entitlement) x 5 (Number Of Months Of Entitlement) = $10,000.00 (Total Award)

PERCENT OF WAGE:

50%: Functional Loss: Can Return To Date Of Injury Occupation
55%: Amputation Or Total Loss Of Use: Can Return To Date Of Injury Occupation
75%: Cannot Return To Date Of Injury Occupation

$4,000.00 X 50% = $2,000.00

$4,000.00 X 55% = $2,200.00

$4,000.00 X 75% = $3,000.00

1. 10% P.I. Minor Arm Can RTW (Return to Date of Injury Occupation)
2. 50% P.I. By Amputation Fourth Finger (Little/Pinky) Can RTW
3. 20% P.I. Left Leg Cannot RTW

AMW		% OF AMW (50%, 55%, 75%)		Monthly Entitlement
1. $4,000.00	X	50 %	=	$2,000.00
2. $4,000.00	X	55 %	=	$2,200.00
3. $4,000.00	X	75 %	=	$3,000.00

Number Of Months For Body Part		% Of Impairment		Months Of Entitlement
1. 50	X	10 %	=	5
2. 4	X	50 %	=	2
3. 50	X	20 %	=	10

Monthly Entitlement		Months Of Entitlement		Total Award
1. $2,000.00	X	5	=	$10,000.00
2. $2,200.00	X	2	=	$4,400.00
3. $3,000.00	X	10	=	$30,000.00

PERCENT OF AMW:

50%: Functional Loss: Can Return To Date Of Injury Occupation

55%: Amputation Or Total Loss Of Use: Can Return To Date Of Injury Occupation

75%: Cannot Return To Date Of Injury Occupation

$4,000.00 X 50% = $2,000.00

$4,000.00 X 55% = $2,200.00

$4,000.00 X 75% = $3,000.00

Tooth Loss & Facial Scarring

Who Issues Facial & Tooth Loss Awards

ICA CLAIMS DIVISION!

Scheduled Permanent Impairment

Issue 104 checking numbers 6 & 8. Submit supporting medical documentation

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address	ICA Claim No. _____ Soc. Sec. No. _____ SSN not required if correct ICA claim number is provided
Authorized Third Party Administrator (TPA) Name and Address	Carrier Claim No. _____ Employer _____
Claimant's Name and Address	Address _____ Date of Injury _____

☐ 1. Claim is accepted.

☐ 2. Claim is denied.

☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.

☐ 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:

- ☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
- ☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.

☐ 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.

☒ 6. Temporary compensation and active medical treatment terminated on **Within 30 days** because claimant was discharged.

☐ 7. Injury resulted in no permanent disability.

☒ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.

☐ 9. Petition to Reopen accepted.

☐ 10. Petition to Reopen denied.

☐ 11. Other:

Mailed on: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

Form 107

NOTICE OF PERMANENT DISABILITY AND REQUEST FOR DETERMINATION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

You are hereby notified of a permanent disability, pursuant to the provisions of A.R.S. 23-1047. The Industrial Commission of Arizona is hereby requested to examine this claim to determine the amount of further compensation, if any, to which claimant may be entitled. Copies of all pertinent reports necessary to make such a determination are herewith forwarded to the Commission.

The type of disability is:

1. Unscheduled permanent partial disability.

- ☐ a. Pursuant to A.R.S. 23-1044-C
- ☐ b. Pursuant to A.R.S. 23-1065-B (Submit proof of prior scheduled award and termination date)
- ☐ c. Pursuant to A.R.S. 23-1065-C (Substantiating medical and employer verification attached)
- ☐ d. Pursuant to pre-1-1-86 apportionment statutes (Specify which section)

☒ 2. Permanent facial disfigurement or loss of teeth (Specify which category)

☐ 3. Fatal with non-enumerated dependents.

☐ 4. Fatal where dependents are only partially dependent upon deceased's earnings for support at time of injury.

☐ 5. Non-enumerated permanent total disability.

☐ 6. Advance payments voluntarily made will be credited against permanent compensation awarded. Advance payments will be as follows:

Please Provide Details: _____

Mailed On: _____ By: _____

NUMBER OF MONTHS OF DISABILITY FOR TEETH

1	Tooth	=	.64	Months
2	Teeth	=	1.28	Months
3	Teeth	=	1.92	Months
4	Teeth	=	2.57	Months
5	Teeth	=	3.21	Months
6	Teeth	=	3.85	Months
7	Teeth	=	4.50	Months
8	Teeth	=	5.14	Months
9	Teeth	=	5.78	Months
10	Teeth	=	6.42	Months
11	Teeth	=	7.07	Months
12	Teeth	=	7.71	Months
13	Teeth	=	8.35	Months
14	Teeth	=	9.00	Months
15	Teeth	=	9.64	Months
16	Teeth	=	10.28	Months
17	Teeth	=	10.92	Months
18	Teeth	=	11.57	Months
19	Teeth	=	12.21	Months
20	Teeth	=	12.85	Months
21	Teeth	=	13.50	Months
22	Teeth	=	14.14	Months
23	Teeth	=	14.78	Months
24	Teeth	=	15.42	Months
25	Teeth	=	16.07	Months
26	Teeth	=	16.71	Months
27	Teeth	=	17.35	Months
28	Teeth	=	18.00	Months

In the manual

Upon receipt of the Form 104 and Form 107 issued by the insurance carrier or self-insured employer indicating loss of teeth, the Industrial Commission will issue the appropriate award.

LOSS OF TEETH

LOSS OF 2 TEETH = 1.28 months

ENTITLED TO 55% OF THE AMW

$4,000.00 X 55% = $2,200.00

$2,200.00 X 1.28 = $2,816.00

ICA will issue an award finding Applicant lost 2 teeth and is entitled to $2,200.00 for 1.28 months for a total award of $2,816.00.

NOTICE OF PERMANENT DISABILITY
AND REQUEST FOR DETERMINATION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

You are hereby notified of a permanent disability, pursuant to the provisions of A.R.S. 23-1047. The Industrial Commission of Arizona is hereby requested to examine this claim to determine the amount of further compensation, if any, to which claimant may be entitled. Copies of all pertinent reports necessary to make such a determination are herewith forwarded to the Commission.

The type of disability is:

1. Unscheduled permanent partial disability.

- ☐ a. Pursuant to A.R.S. 23-1044-C
- ☐ b. Pursuant to A.R.S. 23-1065-B (Submit proof of prior scheduled award and termination date)
- ☐ c. Pursuant to A.R.S. 23-1065-C (Substantiating medical and employer verification attached)
- ☐ d. Pursuant to pre-1-1-86 apportionment statutes (Specify which section)

☒ 2. Permanent facial disfigurement or loss of teeth (Specify which category)

☐ 3. Fatal with non-enumerated dependents.

☐ 4. Fatal where dependents are only partially dependent upon deceased's earnings for support at time of injury.

☐ 5. Non-enumerated permanent total disability.

☐ 6. Advance payments voluntarily made will be credited against permanent compensation awarded. Advance payments will be as follows:

Please Provide Details: _____

Mailed On: _____ By: _____

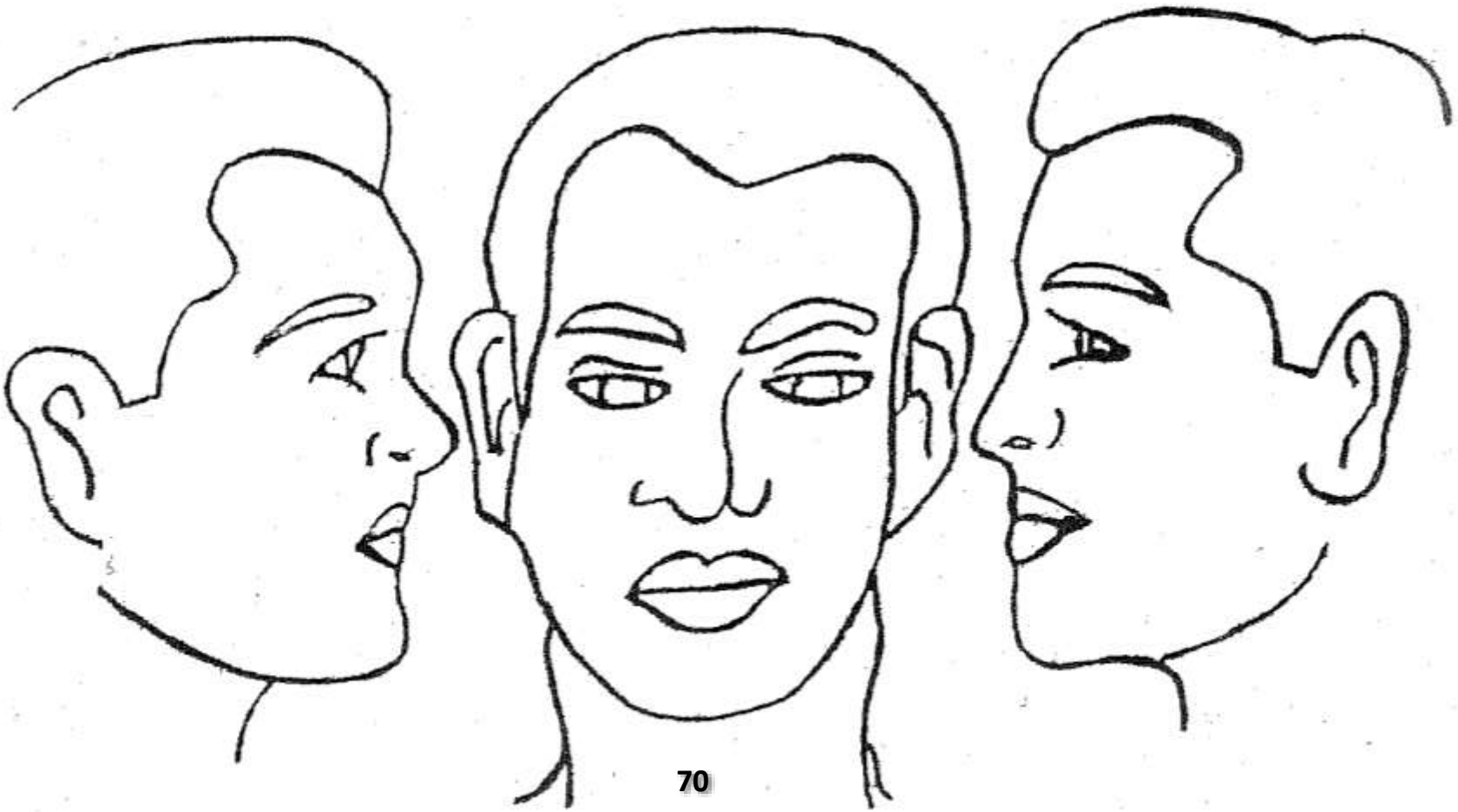
74 & 96

INJURED WORKER'S NAME: _____ SCAR VISIBLE FROM: _____ FEET: _____

ICA CASE NO.: _____ DOI: _____ LENGTH OF SCAR: _____

SOCIAL SECURITY NO.: _____ COMMENTS: _____

VIEWED BY: _____ _____



FACIAL DISFIGUREMENT

FACIAL SCAR = 2 months

Entitled to 55% of the AMW

$4,000.00 x 55% = $2,200.00

$2,200.00 x 2 months = $4,400.00

ICA will issue an award finding that applicant is entitled to 2 months for facial disfigurement and is entitled to $2,200.00 for 2 months for a total of $4,400.00.

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005

Applicant,

VS.

Defendant Employer,

Defendant Insurance Carrier.

ICA Case No:

Carrier Claim No:

Date of Injury:

FINDINGS AND AWARD FOR SCHEDULED PERMANENT DISABILITY

FINDINGS

1. Applicant sustained a compensable injury by accident arising out of and in the course of employment on DATE.

2. As a result of the injury applicant sustained a permanent FACIAL DISFIGUREMENT/TOOTH LOSS and is entitled to compensation in the sum of DOLLARS monthly for a period of NUMBER OF months, as provided in A.R.S. 23-1044, B (22), which equals the total sum of $TOTAL AWARD, payable by the above-named carrier.

AWARD

1. Applicant is awarded benefits as set forth in Finding #2.

If you do not agree with this award and wish a hearing, then your written request for hearing must be received in either office of The Industrial Commission of Arizona within NINETY (90) DAYS from the date of this award pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH REQUEST FOR HEARING IS RECEIVED WITHIN THAT NINETY (90) DAY PERIOD, THIS AWARD IS FINAL.

Dated at Phoenix, Arizona

DATE

The Industrial Commission of Arizona

By: _____
Special Assistant

Phoenix Office: Industrial Commission of Arizona
800 W. Washington
Phoenix, Arizona 85007-2922

Tucson Office: Industrial Commission of Arizona
2675 E. Broadway
Tucson, Arizona 85716-5342

Scheduled Permanent Impairment Award Issued By ICA

Fatality

Fatalities Blue Tab

Fatalities-Dependent's Benefits

OSHA/ADOSH requires notification of any fatality within eight hours.

Notify ICA Claims Division of any fatality within 24 hours or the next business day.

Carrier is liable for all medical expenses related to the injury and a maximum of $5,000.00 toward funeral expenses.

Surviving spouse, no children: **66 2/3% of the AMW of the deceased until death or remarriage. At the time of remarriage, the carrier is to pay 24 months of comp in a lump sum.**

Surviving Spouse with children: **35% of AMW to spouse and the additional sum of 31 2/3% of AMW for the children to share and share alike to continue until all children die, marry or reach the age of 18 or 22 if enrolled full time in an accredited institution.**

Burial expense of a dependent during dependency is $800.00

When is dependency defined?

January 06, 1994 the Arizona Supreme court issued opinions regarding the interpretation of A.R.S. § 23-1064(B). Dependency will be determined as of the date of death, not the date of the initial injury. *Rico v. Industrial Comm'n,* 177 Ariz. 197, 866 P.2d 865 (1994) and *Dunn v. Industrial Comm'n,* 177 Ariz. 399, 966 P.2d 858 (1994)

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

CLAIM FOR DEPENDENT'S BENEFITS – FATALITY

CHECK APPROPRIATE BOX:

- ☐ SPOUSE
- ☐ SPOUSE WITH DEPENDENT CHILDREN
- ☐ DEPENDENT CHILDREN *(Must be filed by guardian)*
- ☐ PARENTS
- ☐ OTHER DEPENDENTS
- ☐ BURIAL EXPENSE ONLY

INFORMATION REGARDING DECEASED:

1. Name of Deceased: _____ Soc. Sec. # *: _____
2. Date of Birth: _____ Date of Death: _____
3. Date of Injury: (If different from date of death): _____
4. Deceased's Address: _____
   _____
5. Employer at time of death: _____
   Employer's address: _____
   _____
6. Briefly state cause of death: _____
   _____
   _____
7. List name and address of health care providers that treated deceased in the last two years and state condition treated:
   _____
   _____
   _____

CLAIM FOR SPOUSAL BENEFITS: *(Provide certified copy of marriage certificate.)*

1. Your Full Name: _____ Date of Birth: _____
2. Your Address: _____
   _____
3. Date of Marriage to Deceased: _____
   Place of Marriage: _____
4. Were You or Deceased Married Previously? ☐ Yes ☐ No If yes, state details and provide copies of divorce decrees. _____
   _____
   _____

The Industrial Commission of Arizona

Claims Division

P.O. Box 19070
Phoenix, Arizona 85005-9070

RUBY TATE, CLAIMS MANAGER
PHONE: (602) 542-4661
FAX: (602) 542-3373

You Have 21 Days To Accept Or Deny The Claim For Dependent's Benefits

DATE

CARRIER NAME
CARRIER ADDRESS

NOTIFICATION OF CLAIM FOR DEPENDENT'S BENEFITS – FATALITY

RE:
ICA CASE NO:
DATE OF INJURY:
DATE OF DEATH:
EMPLOYER:
CARRIER CLAIM NO:

Attached is a copy of the Claim for Dependent's Benefits filed by **filing party**.

You are required to issue a Notice of Claim Status indicating your acceptance or denial of the claim within TWENTY-ONE DAYS from the date of this notice pursuant to A.R.S. 23-1061.

The Claims Division
Compliance Section

Box #11 is Used to Accept or Deny the Claim for Dependent's Benefits

NOTICE OF CLAIM STATUS

INCLUDE ICA#

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
	SSN not required if correct ICA claim number is provided
Authorized Third Party Administrator (TPA) Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date of Injury _____

- [ ] 1. Claim is accepted.
- [ ] 2. Claim is denied.
- [ ] 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- [x] 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:
  - [ ] A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - [x] B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- [ ] 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
- [ ] 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- [ ] 7. Injury resulted in no permanent disability.
- [ ] 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
- [ ] 9. Petition to Reopen accepted.
- [ ] 10. Petition to Reopen denied.
- [x] 11. Other: Dependent Benefits are accepted.

Mailed on: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

106 - Fatality

INCLUDE ICA#

If there are multiple guardians with multiple children, a new 106 is to be issued to each family

notified that the above-named insurance carrier has determined that you are entit
ath Benefits:

1. Statute under which compensation is payable: A.R.S. 23 - 1046

ntage and type of disability: Fatality

nt of compensation and method of payment:

Mailed On: By:
Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #:

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

Seminar Manual Example: Dependent upon the deceased at the time of death were the following:
(Surviving Spouse's Name)
(Child + Date of Birth)
The sum of $_____ monthly (35% of the AMW) for the surviving spouse and the further sum of $ _____(31 2/3% of the AMW) for the child until the child reaches the age of 18 years or until the age of 22 years if the child is enrolled as a full-time student in any accredited educational institution or if over 18 years and incapable of self-support until the child becomes capable of self-support. The first payment effective as of the day after the death of the deceased. A.R.S. § 23-1046(A)(2).
If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____ for the minor child, payable to (name of guardian), guardian of said minor child, the first payment effective _____
In the event and at the time of remarriage the surviving spouse is due two years of the monthly entitlement (35% of the AMW if there is a dependent child, 66 2/3% of the AMW if the child is no longer receiving benefits) payable in one lump sum.
In the event of remarriage or death of a surviving spouse the monthly entitlement for the dependent child will increase from 31 2/3% of the AMW to 66 2/3% of the AMW. A.R.S. § 23-1046(A)(3).

Examples Available in the Claims Manual

(Copy & Paste as Applicable)

- **Spouse Only, No Children**
- **Surviving Spouse, One Child**
- **Surviving Spouse, Two Children**
- **Surviving Spouse, Three or More Children**
- **Surviving Children, No Surviving Spouse or Surviving Spouse Subsequently Dies or Remarries**
- **Surviving Children Only with No Surviving Spouse or Surviving Spouse Dies or Remarries. *Version of A.R.S. § 23-1046 (1999), prior to its amendment by A.R.S. § 23-1046 (2007)**

Thank you for joining us.
Q&A